STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

April 7, 2021

James Scott, Director
Division of Program Operations
Department of Health & Human Services
Centers for Medicare & Medicaid Services
601 East 12th Street Room 355
Kansas City, Missouri 64106

SUBJECT: State Plan Amendment
Title XIX, Social Security Act
Transmittal #2021-0004

Dear Mr. Scott:

Please find attached an amendment for North Carolina's State Plan under Title XIX of the Social Security Act for the Medical Assistance Program. The affected pages are Attachment 4.19-A, pages 1-4, 4a-4e, 5-6, 8, 8b-8e, 9-13, 13b-13c, 14-19, 19c-19i, and 20-22.

This amendment will revise inpatient payment methodology for Medical and Remedial Care and Services. Revision to methodology includes incorporating enhanced Base Rates for inpatient claims reimbursement, Graduate Medical Education (GME) payment methodology, and Disproportionate Share Hospital (DSH) payments for managed care.

This amendment is effective July 1, 2021.

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact me or Betty J. Staton at 919-538-3215.

Sincerely,

Mandy K. Cohen, MD, MPH
Secretary

Enclosures

WWW.NCDHHS.GOV
TEL 919-855-4800 • FAX 919-715-4645
LOCATION: 101 BLAIR DRIVE • ADAMS BUILDING • RALEIGH, NC 27603
MAILING ADDRESS: 2001 MAIL SERVICE CENTER • RALEIGH, NC 27699-2000

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HOSPITAL INPATIENT REIMBURSEMENT PLAN

REIMBURSEMENT PRINCIPLES

Hospitals licensed by the State of North Carolina will be paid for acute care general hospital inpatient services using the DIAGNOSIS RELATED GROUPS (DRG) RATE-SETTING METHODOLOGY described below, except as noted in the EXCEPTIONS TO DRG REIMBURSEMENT.

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DRG RATE SETTING METHODOLOGY

(a) Diagnosis Related Groups is a system of classification for hospital inpatient services. For each hospital admission, a single DRG category shall be assigned based on the patient's diagnosis, age, procedures performed, length of stay, and discharge status. For claims with dates of services prior to January 1, 1995 payments shall be based on the reimbursement per diem in effect prior to January 1, 1995. However, for claims related to services where the admission was prior to January 1, 1995 and the discharge was after December 31, 1994, then the greater of the total per diem for services rendered prior to January 1, 1995, or the appropriate DRG payment shall be made.

(b) The Division of Health Benefits (Division) shall use the DRG assignment logic of the Medicare Grouper to assign individual claims to a DRG category. Medicare revises the Grouper each year in October. The Division shall install the most recent version of the Medicare Grouper implemented by Medicare to be effective October 1 of each following rate year. Effective October 1, 2012, the Division shall install the most recent version of the Medicare Grouper implemented by Medicare to be effective October 1 of each rate year. The initial DRG in Version 12 of the Medicare Grouper, related to the care of premature neonates and other newborns numbered 385 through 391, shall be replaced with the following classifications:

385 Neonate, died or transferred, length of stay less than 3 days
801 Birth weight less than 1,000 grams
802 Birthweight 1,000 – 1,499 grams
803 Birthweight 1,500 – 1,999 grams
804 Birthweight >=2,000 grams, with Respiratory Distress Syndrome
805 Birthweight >=2,000 grams premature with major problems
810 Neonate with low birthweight diagnosis, age greater than 28 days at admission
389 Birthweight >= 2,000 grams, full term with major problems
390 Birthweight >= 2,000 grams, full term with other problems or premature without major problems
391 Birthweight >= 2,000 grams, full term without complicating diagnoses

Effective October 1, 2008, the premature neonates and other newborn DRGs listed above are replaced by the premature neonates and other newborn DRGs in Version 25 of the Medicare Grouper (i.e. DRGs 789-795).

DRG 789 Neonate, died or transferred, length of stay less than 3 days.

Effective for dates of service on or after October 1, 2017, the below DRG classifications specific to long-acting reversible contraceptives (LARCs) are added to the current Grouper version.

1765 Cesarean Section W CC/MCC with LARC
1766 Cesarean Section W/O CC/MCC with LARC
1767 Vaginal Delivery W Sterilization &/or D&C with LARC
1768 Vaginal Delivery W O.R. Proc Except Sterile &/or D&C with LARC
1769 Postpartum & Post Abortion Diagnoses W O.R. Procedure with LARC
1770 Abortion W D&C, Aspiration Curettage or Hysterectomy with LARC
1774 Vaginal Delivery W Complicating Diagnoses with LARC
1775 Vaginal Delivery W/O Complicating Diagnoses with LARC
1776 Postpartum & Post Abortion Diagnoses W/O O.R. Procedure with LARC
1777 Ectopic Pregnancy with LARC
1779 Abortion W/O D&C with LARC

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(c) DRG relative weights are a measure of the relative resources required in the treatment of the average case falling within a particular DRG category. The average DRG weight for all discharges from a particular hospital is known as the Case Mix Index (CMI). The statewide average CMI for all hospitals is utilized for out-of-state providers.

(1) The Division shall establish relative weights for each utilized DRG based on a recent data set of historical claims submitted for Medicaid recipients. Charges on each historical claim shall be converted to estimated costs by applying the hospital specific cost to charge ratio from each hospital's submitted Medicaid cost report. Cost estimates are standardized by removing direct and indirect medical education costs at the appropriate rates for each hospital.

(2) Relative weights shall be calculated as the ratio of the average cost in each DRG to the overall average cost for all DRGs combined. Prior to calculating these averages, low statistical outlier claims shall be removed from the data set, and the costs of claims identified as high statistical outlier shall be capped at the statistical outlier threshold. The Division of Medical Assistance shall employ criteria for the identification of statistical outliers which are expected to result in the highest number of DRGs with statistically stable weights.

(3) The Division of Health Benefits shall employ a statistically valid methodology to determine whether there are a sufficient number of recent claims to establish a stable weight for each DRG. For DRGs lacking sufficient volume, the Division shall set relative weights using DRG weights generated from the North Carolina Medical Data Base Commission's discharge abstract file covering all inpatient services delivered in North Carolina hospitals. For DRGs in which there are an insufficient number of discharges in the Medical Database Commission data set, the Division sets relative weights based upon the published DRG weights for the Medicare program.

(4) Relative weights shall be recalculated when the new version of the DRG Grouper is installed by the Division of Health Benefits to be effective October 1 of the rate year. When relative weights are recalculated, the overall average CMI will be kept constant. Then a two and one-tenth percent(2.1%) reduction factor shall be applied uniformly to the case weighting factor assigned to each DRG.

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(d) The Division of Health Benefits shall establish a unit value for each hospital which represents the DRG payment rate for a DRG with a relative weight of one. This rate is established as follows:

(1) Using the methodology described in Paragraph (c) of this plan, the Division shall estimate the cost less direct and indirect medical education expense on claims for discharges occurring during calendar year 1993, using cost reports for hospital fiscal years ending during that period or the most recent cost report available. All cost estimates are adjusted to a common 1994 fiscal year and inflated to the 1995 rate year.

The average cost per discharge for each provider is calculated. (See Exhibit page 25 of the plan). The state reserves the right to rebase based upon a year selected by the state.

(2) Using the DRG weights to be effective on January 1, 1995, a CMI is calculated for each hospital for the same population of claims used to develop the cost per discharge amount in Subparagraph (d)(1) of this plan. Each hospital's average cost per discharge is divided by its CMI to get the cost per discharge for a service with a DRG weight of one.

(3) The amount calculated in Subparagraph (d)(2) of this plan is reduced by7.2% to account for outlier payments.

(4) Effective for dates of service provided on or after December 1, 2016 the individualized base DRG rates for hospital inpatient services are equal to the statewide median rate of $2,704.50. Effective for dates of service on or after December 1, 2016 all primary affiliated teaching hospitals for the University of North Carolina Medical Schools' base rates shall not be included in the calculation of the statewide median rate and shall have their base rate equal to their respective base rate in effect on January 1, 2015. New hospitals inpatient rates will be established based on the statewide median rate. Existing hospitals that enter into a Change of Ownerships (CHOW) shall have the hospital's rates established based on the previous hospital's rates. Critical Access Hospitals' (CAH) rates will be established based on the same hospital's Acute Care Hospital rates. The actual reimbursement amount for a DRG billing is the product of the hospital specific rate times the relative weight and unit value for that DRG exclusive of add-ons (i.e. DSH and outliers).

(5) Effective for dates of service between July 1, 2021 – June 30, 2022, in-state hospital base rates will be calculated according to the methodology below. All rates are published on the DHB website at: [https://medicaid.ncdhhs.gov/fee-schedule-index].

(A) The individualized DRG rates for acute hospital inpatient services for all non-critical access hospitals—other than hospitals owned or controlled by the University of North Carolina Health Care System (UNCHCS), as defined in N.C. Gen. Stat. § 116-37, Novant Health Mint Hill Medical Center, and Pitt County Memorial Hospital, Inc. dba Vidant Medical Center willbe set according to the methodology below, based on data contained in the FFY 2020 MRI/GAP Plan (State supplemental payments plan) as of January 31, 2021 ("Base Year"). All critical access hospitals (CAHs) as defined by 42 USC 1395i-4 will be reimbursed based on the methodology described in subparagraph (d)(5)(B) of this plan and are not subject to or included in calculations related to the methodology described in this subparagraph(5)(A).

i. Separately calculate the following for the two hospital classes below.

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a) All non-State-owned hospitals qualified to certify public expenditures in accordance with 42 CFR 433.51(b) that are not CAHs

b) All hospitals not qualified to certify public expenditures that are notCAH

ii. Determine each hospital's inpatient aggregate Medicaid and uninsured acute care costs as a percentage of the total inpatient Medicaid and uninsured acute care costsof its respective class from paragraph (d)(5)(A)(i) ("percentage") based on data contained in FFY 2020 MRI/GAP Plan as of January 31, 2021. Novant Health Mint Hill Medical Center shall be excluded from this calculation.

iii. Multiply each hospital's percentage from paragraph (d)(5)(A)(ii) by the total inpatient Medicaid payments of its respective class from paragraph (d)(5)(A)(i), to equal the hospitals' sum of DRG payments for acute care hospital services, UPL payments, and enhanced payments based on data contained in FFY 2020 MRI/GAP Plan as of January 31, 2021. The total sum available for the class described in paragraph (d)(5)(A)(i)(b) shall be reduced by $5,105,154.

iv. Subtract each hospital's estimated outlier payments as determined by the Department and GME payments as calculated under Graduate Medical Education Payment Methodology, (Attachment 4.19-A, pages 8b-8e) from the amount calculated in paragraph (d)(5)(A)(iii).

v. For each hospital, divide the amount calculated in paragraph (d)(5)(A)(iv) by its Medicaid case-mix index adjusted discharges contained in FFY 2020 MRI/ GAP Plan as of January 31, 2021 to establish the hospital-specific base payment per discharge.

vi. Trend the amount calculated in paragraph (d)(5)(A)(v) forward from the Base Year October 1, 2019 to July 1, 2021 by 1.0424% using the 2021 CMS Inpatient Hospital PPS Market Basket Update less Productivity Adjustment Final Rule, representing 1.75 years of trend.

vii. The actual reimbursement amount of a DRG billing is the product of the hospital specific rate times the relative weight and unit value for that DRG exclusive of add-ons (i.e. DSH, GME, and outliers).

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(B) Individualized DRG payment rate for CAHs will be set to approximate each CAH's Medicaid allowable cost and UPL payments on a per-discharge basis. DRG payment rate will be set according to the following methodology:

i. Calculate Medicaid allowable costs and UPL payments ("total payments") for each CAH based on data contained in FFY 2020 MRI/GAP Plan as of January 31, 2021.

ii. Divide each hospital's total payments by its Medicaid case-mix index adjusted discharges contained in FFY 2020 MRI/GAP Plan as of January 31, 2021.

iii. Trend the amount calculated in paragraph (d)(5)(B)(ii) forward from the Base Year October 1, 2019 to July 1, 2021 by 1.0424% using the 2021 CMS Inpatient Hospital PPS Market Basket Update less Productivity Adjustment Final Rule, representing 1.75 full years of trend.

iv. The actual reimbursement amount of a DRG billing is the product of the hospital specific rate time the relative weight and unit value for that DRG exclusive of add-ons. (i. e. DSH, GME, and Outliers).

(C) The individualized DRG payment rate for hospitals owned or controlled by the University of North Carolina Health Care System (UNCHCS), as defined in N.C. Gen. Stat. § 116-37, will be set according to the following methodology, with the exception of Chatham Hospital, for which the DRG rate will be set according to the payment rate for CAHs as determined under subparagraph (d)(5)(B):

i. Calculate Medicaid and uninsured costs for each hospital owned or controlled by UNCHCS based on data contained in FFY2020 MRI/GAP Plan as of January 31, 2021.

ii. Multiply Medicaid and uninsured costs for each hospital owned or controlled by UNCHCS by the ratio of aggregate inpatient payments to aggregate inpatient Medicaid and uninsured cost for hospitals included in the class defined under (d)(5)(A)(i)(b).

iii. Subtract each hospital's estimated outlier payments as determined by the Department and GME payments as calculated under Graduate Medical Education (GME) Payment Methodology, (Attachment 4.19-A, pages 8b-8e), from the amount calculated in paragraph (d)(5)(C)(ii).

iv. For each hospital, divide the amount calculated in paragraph (d)(5)(C)(iii) byits Medicaid case-mix index adjusted discharges contained in the FFY 2020 MRI/GAP Plan as of January 31, 2021 to establish the hospital-specific base payment per discharge.

v. Trend the amount calculated in paragraph (d)(5)(C)(iv) forward from the Base Year October 1, 2019 to July 1, 2021 by 1.0424% using the 2021 CMS Inpatient Hospital PPS Market Basket Update less Productivity Adjustment Final Rule, representing 1.75 full years of trend.

vi. The actual reimbursement amount of a DRG billing is the product of the hospital specific rate times the relative weight and unit value for that DRG exclusive of add-ons (i.e. DSH, GME, and outliers).

(D) The individualized DRG payment rate for Pitt County Memorial Hospital, Inc. dba Vidant Medical Center will be set according to the following methodology:

i. Calculate Medicaid and uninsured costs for Pitt County Memorial Hospital based on data contained in FFY 2020 MRI/GAP Plan as of January 31, 2021.

ii. Multiply Pitt County Memorial Hospital's total Medicaid and uninsured costs by the ratio of aggregate inpatient Medicaid payments to aggregate inpatient Medicaid and uninsured cost calculated for hospitals included in the class defined under (d)(5)(A)(i)(a).

iii. Subtract Pitt County Memorial Hospital's estimated outlier payments as determined by the Department and GME payments as calculated under Graduate Medical Education (GME) Payment Methodology, (Attachment 4.19-A, pages 8b-8e), from the amount calculated in paragraph(d)(5)(D)(ii).

iv. Divide the amount calculated in paragraph (d)(5)(D)(iii) by Pitt County Memorial Hospital's Medicaid case-mix index adjusted discharges contained in the FFY 2020 MRI/GAP Plan as of January 31, 2021 to establish Pitt County Memorial Hospital's specific base payment per discharge.

v. Trend the amount calculated in paragraph (d)(5)(D)(iv) forward from the Base Year October 1, 2019 to July 1, 2021 by 1.0424% using the 2021 CMS Inpatient Hospital PPS Market Basket Update less Productivity Adjustment Final Rule, representing 1.75 full years of trend.

vi. If the specific base payment per discharge is this section would result in payments to Vidant in excess of the upper payment limit calculation required by 42 C.F.R 447.272, the hospital's specific base payment per discharge will be reduced to ensure compliance with the upper payment limit.

vii. The actual reimbursement amount of a DRG billing is the product of Pitt County Memorial Hospital's specific rate times the relative weight and unit value for that DRG exclusive of add-ons (i.e. DSH, GME, and outliers).

(E) The individualized DRG payment rate for Novant Health Mint Hill Medical Center will be set according to the following methodology:

i. The individualized DRG payment rate for Novant Health Mint Hill Medical Center shall be $10,839.

ii. Trend the amount calculated in paragraph (d)(5)(E)(i) forward from the Base Year October 1, 2019 to July 1, 2021 by 1.0424% using the 2021 CMS Inpatient Hospital PPS Market Basket Update less Productivity Adjustment Final Rule, representing 1.75 full years of trend.

iii. The actual reimbursement amount of a DRG billing is the product of the hospital specific rate times the relative weight and unit value for that DRG exclusive of add-ons (i.e. DSH, GME, and outliers).

(6) For dates of service after June 30, 2022, the individualized DRG rates for in-state hospital inpatient services calculated in (d)(5) will be adjusted at the start of each state fiscal year (July1) using the CMS Inpatient Hospital PPS Market Basket Update less Productivity Adjustment Final Rule most recently published in the Federal Register as of November 1, prior to the start of the applicable federal fiscal year (e.g. the most recent market basket index published before November 1, 2021 would be applied to rates starting July 1, 2022).

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(7) Changes of Ownership and New Facilities.

(A) Acute care hospitals which are newly licensed subsequent to September 30, 2020 and therefore not a component of the 2020 MRI/GAP Plan shall have their individualized DRG Base rate established at a percentile of the base rate of acute care hospitals in the state fiscal year of the hospital's effective date. Acute care hospitals with greater than 50 licensed beds shall have their individualized DRG Base rate established at the 50th percentile. Acute care hospitals with 50 or fewer licensed beds shall have their individualized DRG Base rate established at the 80th percentile. (For example, if a newly licensed and enrolled acute care hospital had a beginning effective date of August 1, 2021, their individualized DRG Base rate is established at 50th percentile Medicaid DRG Base Rate of all acute care hospitals with rate effective July 1, 2021.)

(B) Critical Access Hospitals which are newly licensed subsequent to September 30, 2020 and therefore not a component of the 2020 MRI/GAP Plan shall have their individualized DRG Base rate established at the 50th percentile of critical access hospitals in the state fiscal year of the hospital's effective date. (For example, if a newly licensed and enrolled critical accesshospital had a beginning effective date of August 1,2021, their individualized DRG Base rate is established at median Medicaid DRG Base Rate of all critical access hospitals with rate effective July 1, 2021.)

(C) Existing licensed hospitals which change ownership or status shall keep their existing individualized DRG Base rate. (For example, if a public acute care hospital converted to a non-public acute care hospital, the converted acute care hospital would retain its previous DRG Base Rate. If non-public critical access hospital converted to a public critical access hospital, the converted critical access hospital would retain its existing DRG Base Rate.)

(D) Existing licensed hospitals which change ownership between acute care hospital and critical access hospital status shall have their new individualized DRG Base rate established in their new status (Acute or CAH) pursuant to paragraphs (d)(7)(A)and (B).

(E) The combining of two or more existing licensed hospitals shall have their new DRG Base Rate determined as follows:

i. An entity with a new CMS Certification Number (CCN) shall be assigned a percentile DRG Base Rate pursuant to paragraph(d)(7)(A) and(d)(7)(B). These hospitals' DRG Base Rate will be subsequently adjusted pursuant to paragraph (d)(6).

ii. An entity with a retained CMS Certification Number (CCN) shall retain the same DRG Base Rate. These hospitals' DRG Base Rate will be subsequently adjusted pursuant to paragraph (d)(6).

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(e) Reimbursement for capital expense is included in the DRG hospital rate described in Paragraph (d) of this plan.

(f) Cost outlier payments are an additional payment made at the time a claim is processed for exceptionally costly services. These payments shall be subject to retrospective review by the Division of Health Benefits, on a case-by-case basis. Cost Outlier payments will be reduced if and to the extent that the preponderance of evidence on review supports a determination that the associated cost either exceeded the costs for services that were not medically necessary or was for services not covered by the North Carolina Medical Assistance program.

(1) A cost outlier threshold shall be established for each DRG at the time DRG relative weights are calculated, using the same information used to establish those relative weights. The cost threshold is the greater of twenty-five thousand dollars ($25000) or mean cost for the DRG plus 1.96 standard deviations.

(2) Charges for non-covered services and services not reimbursed under the inpatient DRG methodology (such as professional fees) shall be deducted from total billed charges. The remaining billed charges are converted to cost using a hospital specific total cost to total charge ratio not from the cost report but developed. The cost to charge ratio excludes medical education costs.

(3) If the net cost for the claim exceeds the cost outlier threshold, a cost outlier payment is made at 75% of the costs above the threshold.

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(g) Day outlier payments are an additional payment made for exceptionally long lengths of stay on services provided to children under six at disproportionate share hospitals and children under age one at non-disproportionate share hospitals. These payments shall be subject to retrospective review by the Division of Medical Assistance, on a case-by-case basis. Day outlier payments will be reduced if and to the extent that the preponderance of evidence on review supports a determination that the associated cost either exceeded the costs or was for services that were not medically necessary or for services not covered by the North Carolina Medical Assistance program.

(1) A day outlier threshold shall be established for each DRG at the time DRG relative weights are calculated, using the same information used to establish the relative weights. The day outlier threshold is the greater of 30 days or the arithmetical average length of stay for the DRG plus 1.50standard deviations.

(2) A day outlier per diem payment may be made for covered days in excess of the day outlier threshold at 75% of the hospital's payment rate for the DRG rate divided by the DRG average length stay.

(h) Services which qualify for both cost outlier and day outlier payments under this plan shall receive the greater of the cost outlier or day outlier payment.

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EXCEPTIONS TO DRG REIMBURSEMENT

(a) Covered psychiatric and rehabilitation inpatient services provided in either specialty hospitals, Medicare recognized Long Term Acute Care Hospitals (LTCH), Medicare recognized distinct part units (DPU), or other beds in general acute care hospitals shall be reimbursed on a per diem methodology.

(1) Prior to October 1, 2008, psychiatric inpatient services are defined as admissions where the primary reason for admission would result in the assignment of a psychiatric DRG code in the range 424 through 437 and 521 through 523**.** Effective October 1, 2008, the assignment of a psychiatric DRG code is in the range 880 through 887 or 894 through 897 or 876. All services provided by specialty psychiatric hospitals are presumed to come under this definition.

Prior to October 1, 2008, rehabilitation inpatient services are defined as admissions where the primary reason for admissions would result in the assignment of DRG 462. Effective October 1, 2008, the assignment of a rehabilitation DRG code is 945 or 946. All services provided by specialty rehabilitation hospitals and Medicare recognized Long Term Acute Care Hospitals (LTCH) are presumed to come under this definition.

(2) When a patient has a medically appropriate transfer from a medical or surgical bed to psychiatric or rehabilitative distinct part unit within the same hospital or to a specialty hospital the admission to the distinct part unit or the specialty hospital shall be recognized as a separate service which is eligible for reimbursement under the per diem methodology.

Transfers occurring within general hospitals from acute care services to non-DPU psychiatric or rehabilitation services are not eligible for reimbursement under this Section. The entire hospital stay in these instances shall be reimbursed under the DRG methodology.

(3) The per diem base rate for psychiatric services is established at the lesser of the actual cost or the calculated median rate of all hospitals providing psychiatric services, as derived from the 2003 Medicaid cost report or the most recent as filed cost report, trended forward to the rate year. Providers that routinely provide psychiatric services and whose base rate trended forward to State Fiscal Year 2005 is less than their rate as of October 1, 2004, shall have their base rate established at the October 1, 2004 amount and trended forward in subsequent years.

(4) Hospitals that do not routinely provide psychiatric services shall have their rate set at the median rate for all other psychiatric hospitals in paragraph (3) above.

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(5) Effective for dates of service on or after October 1, 2017, the per diem rate for Long Term Acute Care Hospitals (LTCH) is established at a minimum of 65% of the hospitals' actual cost derived from the most recent filed cost reports. There will not be any rate adjustment applied to hospitals whose per diem rate is above 65% of their actual cost derived from their FY 2016 cost report. These providers will continue to receive the per diem rate in effect as of September 30, 2017.

(6) Effective July 1, 2021, the per diem base rate for psychiatric services will be set to approximate each hospital's Medicaid allowable psychiatric costs using data contained in the FFY 2020 MRI/GAP Plan as of January 31, 2021.

(7) Hospital psychiatric units which are newly licensed subsequent to September 30, 2020 and therefore not a component of the 2020 MRI/GAP Plan shall have their individualized per diem established at a percentile of the per diems for all acute care hospitals in the state with psychiatric units. Acute care hospitals with greater than 50 licensed beds shall have their per diem established at the 50th percentile of the Base Year per diem inflated to the hospital's effective date. Acute care hospitals with 50 or fewer licensed beds shall have their per diem established at the 80th percentile of the Base Year per diem inflated to the hospital's effective date. (For example, if a newly licensed and enrolled acute care hospital with greater than 50 licensed beds has a beginning effective date of August 1, 2021, their initial per diem is established at the 50th percentile of the Base Year Medicaid per diem of all acute care hospitals inflated forward to August 1, 2021).

(8) Effective July 1, 2021, the per diem rate for rehabilitation services will be set to approximate each hospital's Medicaid allowable rehabilitation costs using data contained in FFY 2020 MRI/GAPPlan as of January 31, 2021.

(9) Hospital rehabilitation units which are newly licensed which are newly licensed subsequent to September 30, 2020 and therefore not a component of the 2020 MRI/GAP Plan shall have their individualized per diem established at a percentile of the per diems for acute care hospitals in the state. Acute care hospitals with greater than 50 licensed beds shall have their per diem established at the 50th percentile of the Base Year per diem inflated to the hospital's effective date. Acute care hospitals with 50 or fewer licensed beds shall have their per diem established at the 80th percentile of the Base Year per diem inflated to the hospital's effective date. (For example, if a newly licensed and enrolled acute care hospital with greater than 50 licensed beds has a beginning effective date of August 1, 2021, their initial per diem is established at the 50th percentile of the Base Year Medicaid per diem of all acute care hospitals inflated forward to August 1, 2021).

(10) For dates of service after July 1, 2022, the per diem base rates for psychiatric and rehabilitation services established in paragraphs (a)(6) through (a)(9) will be adjusted at the start of each federal fiscal year (October 1) using the CMS Inpatient Hospital PPS Market Basket Update less Productivity Adjustment final rule most recently published in the Federal Register as of November 1 prior to start of the applicable federal fiscal year (e.g. the most recent market basket index published before November 1, 2021 would be applied to rates starting July 1, 2022).

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GRADUATE MEDICAL EDUCATION (GME) PAYMENT METHODOLOGY

Effective July 1, 2021, the Department of Health and Human Services shall calculate Medicaid GME payments to all hospitals with Medicare-approved GME programs based on the methodology below. All Medicare cost report worksheet, column or line references are based upon the Medicare Cost Report (MCR)CMS 2552 - 10 and should be adjusted for any CMS approved successor Medicare Cost Report (MCR).

a. The Department shall perform the following calculation to determine direct graduate medical education (DGME) payments to all hospitals with Medicare-approved GME programs except for the University of North Carolina Hospitals dba UNC Hospitals and Pitt County Memorial Hospital, Inc. dba Vidant Medical Center. GME costs and resident counts for the University of North Carolina Hospitals dba UNC Hospitals and Pitt County Memorial Hospital, Inc. dba Vidant Medical Center shall not be included in the calculations described under subpart (a)(i).

i. The Direct Graduate Medical Education calculation in this subpart (a)(i) shall be updated annually for each hospital on July 1, based on information from each hospital's Healthcare Cost Report Information System (HCRIS) data most recently filed with CMSand available as of the prior September 30, inflated into the current year by use of the Medicare Hospital Inpatient Prospective Payment System (IPPS)and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule less Productivity Adjustment most recently published in the Federal Register as of July 1 ("market basket update"), as follows:

1. Calculate a statewide per-resident average (PRA) by:
   a. Summing the total Interns and Residents Salary and Fringe Costs plus Interns and Residents Other Program Costs as determined from HCRIS data extract of Worksheet A, Column 7, Lines 21 and 22.

   b. Summing the total number of resident full-time equivalents (FTEs) as determined from each hospital's HCRIS data extract of Worksheet S-3, Part 1, Column 9, Line 27.

   c. Dividing total allowable direct costs identified in subpart (a)(i)(1)(a) by total resident FTEs identified in subpart (a)(i)(1)(b).

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2. Multiply the statewide PRA calculated in subpart (a)(i)(1). by each hospital's number of resident FTEs as reported determined by either:
   a. Each hospital's HCRIS data extract from Worksheet S-3, Part 1, Column 9, Line 27, or

   b. The hospital's most recent Medicare Year End Rate Review letter dated prior to July 1 and furnished to the Department by September 1, indicating the projected number of IME resident FTEs for the hospital's current fiscal year.

      (A) The Department shall use each hospital's HCRIS data extract from Worksheet S-3, Part 1, Column 9, Line 27 as a default to determine number of resident FTEs unless the hospital attests that the Medicare Year End Rate Review letter provides a more accurate FTE count.

3. Multiply the amount calculated in subpart (a)(i)(2) by each hospital's Medicaid share of inpatient days as determined from each hospital's HCRIS data as described below. To determine the Medicaid share of inpatient days:
   a. For hospitals reporting FTEs on Worksheet S-3, Part 1, Column 9, Lines 16 or 17:
      (A) The numerator shall be the sum of Medicaid (Title XIX) inpatient days from each hospital's HCRIS data extract of Worksheet S-3, Part 1, Column 7, Lines 14, 16, 17, and 32 plus the total number of paid inpatient Medicaid Managed Care days from Worksheet S-3, Part 1, Column 7, Lines 2, 3, and 4.
      (B) The denominator shall be Total inpatient days from each hospital's HCRIS data extract of Worksheet S-3, Part 1, column 8, Lines 14, 16, 17 and 32.
   b. For all other hospitals:
      (A) The numerator shall be the sum of Medicaid (Title XIX) inpatient days from each hospital's HCRIS data extract of Worksheet S-3, Part 1, Column 7, Lines 14, and 32 plus the total number of paid inpatient Medicaid Managed Care days from Worksheet S-3, Part 1, Column 7, Lines 2.
      (B) The denominator shall be Total inpatient days from each hospital's HCRIS data extract of Worksheet S-3, Part 1, Column 8, Lines 14 and 32.

b. The Direct Graduate Medical Education calculation in this subpart (b) shall be updated annually for each hospital on July 1, based on information from each hospital's Healthcare Cost Report Information System (HCRIS) data most recently filed with CMS and available as of the prior September 30, inflated into the current year by use of the market basket update, as follows to determine DGME payments to the University of North Carolina Hospitals dba UNC Hospitals and Pitt County Memorial Hospital, Inc. dba Vidant Medical Center.

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i. Identify each hospital's Interns and Residents Salary and Fringe Costs plus Interns and Residents Other Program Costs as determined from HCRIS data extract reported on Worksheet B, Part I, Column 21, Row 21 and Column 22, Row 22.

ii. Multiply the amount calculated in subpart (b)(i) by each hospital's Medicaid days ratio, determined based on the methodology described in subpart (a)(i)(3).

c. The Department shall perform the following calculation to determine indirect graduate medical education (IME) payments to all hospitals with Medicare-approved GME programs:

i. Identify each hospital's Medicare IME adjustment factor based on the methodology described in 42 CFR 412.105 except for the limits on the total number of FTE residents described in 42 CFR 412.105(f)(iv). The Department shall use the total number of resident FTEs for each hospital Identified under subpart (a) and (b) to calculate the IME adjustment factor.

ii. Determine the IME base amount by

(A) Multiplying the IME adjustment factor calculated in subpart (c)(i) by the sum of each hospital's HCRIS data extract from Worksheet E, Part A, Line 1 plus Line 3 divided by each hospital's Medicare case mix index as annually published in case mix index tables accompanying the Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule,

(B) For hospitals reporting FTEs on Worksheet S-3, Part 1, Column 9, Lines 16 or 17, divide subpart (c)(ii)(A) by the sum of Medicare discharges from each hospital's HCRIS data extract from Worksheet S-3, Part 1, Column 13, Lines 2, 14, 16, and 17. Multiply the base rate by the sum of Medicaid discharges from Worksheet S-3, Part 1, Column 14, Line 14, 16,and 17, and the in-state paid Medicaid Managed Care discharges from Worksheet S-3, Part 1, Column 14, Lines 2, 3, and 4.

(C) For all other hospitals, divide subpart (c)(ii)(A) by the sum of Medicare discharges from each hospital's HCRIS data extract from Worksheet S-3, Part 1, Column 13, Lines 2 and 14.Multiply the base rate by the sum of Medicaid discharges from Worksheet S-3, Part 1, Column 14, Line 14, and the in-state paid Medicaid Managed Care discharges from Worksheet S-3, Part 1, Column 14, Line 2.

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iii. Multiply the amount calculated in subpart (c)(ii) by each hospital's Case Mix Index for the Medicaid population calculated using MMIS data from the Annual Medicaid Calculation for Recalibration of DRG Weights.

d. The Department shall recalculate GME payment amounts annually on July 1 based on the methodology described in subparts (a)-(c).

e. For hospitals that attest to the Medicare Year End Rate letter described under subpart (a)(i)(2)(b) to determine its resident FTE count, the Department shall:

i. Reconcile the number of resident FTEs reported in the rate review letter with the actual number of residents reported on the relevant year's hospital HCRIS data extract of Worksheet S-3, Part 1, Column 9, Line 27 when available.

ii. Recalculate the relevant year's DGME payments based on the number of resident FTEs reported in the cost report.

iii. Recoup any overpayments or make additional payments to cover any shortfall based on the difference between the amount calculated under subpart (e)(ii) and the amount of DGME payments made in the relevant year.

f. For hospital with new medical residency training programs pursuant to 42 CFR § 413.79 (e), and receiving GME reimbursement pursuant to the State Plan as of June 30, 2021, and with FTEs reported by the hospital's HCRIS data described under subpart (a)(i)(2)(a) to determine its resident FTE count, the Department shall:

i. Reconcile the number of resident FTEs reported in the HCRIS data described under subpart (a)(i)(2)(a) with the relevant year's hospital HCRIS data extract of WorksheetS-3, Part 1, Column 9, Line 27 when available.
ii. This subsection (f) shall sunset effective June 1, 2023.

g. GME payments will be made not more frequently than quarterly.

h. To establish the GME payment amounts which must be subtracted from FFY2020 ("Base Year") calculations under subparagraph (d)(5) of the DRG RATE SETTING METHODOLOGY Section, GME Payments shall be calculated pursuant to subparagraphs (a), (b), and (c) of this GME PAYMENT METHODOLOGY Section using 2018 HCRIS data trended forward from October 1, 2018 to October 1, 2020 by 1.0486% using the 2021 CMS Inpatient Hospital PPS Market Basket Update less Productivity Adjustment Final Rule, representing two full years of trend.

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Upper Payment Limit Payment for Pitt County Memorial Hospital, Inc. dba Vidant Medical Center

In addition to the payments made elsewhere in this plan, Pitt County Memorial Hospital, Inc. dba Vidant Medical Center is eligible for a supplemental payment for inpatient hospital services (the "UPL Payment") that is calculated annually and paid in up to four (4) installments. The UPL Payment will be determined by the difference between what Medicare would pay for the hospital´s Medicaid fee-for-service inpatient services and the hospital´s Medicaid inpatient costs using Medicare cost reporting principles**.** All Medicare cost report worksheet, column, or line - references are based upon the Medicare Cost Report (MCR) CMS 2552-10 and should be adjusted for any CMS approved successor Medicare Cost Report (MCR). The amount that Medicare would pay shall be calculated as follows:

(1) Using the most current available Medicare cost report data, Total Medicare payments to Pitt County Memorial Hospital, Inc. dba Vidant Medical Center shall be derived from the reported Total Medicare Prospective Payments on Worksheet E, Part A, Column 1, Line 59 minus the managed care component of the Direct Graduate Medical Education (DGME). The managed care component of the DGME shall be calculated using the following formula:

a. Worksheet E, Part A, Line 52 minus ((Worksheet E-4, Column 2, Line 29 minus Worksheet E-4, Column 2, Line 30) multiplied by Worksheet E-4, Column 2, Line 46)

(2) Total Medicare Payments shall be inflated from the midpoint of the hospital's cost report period to the midpoint of the UPL demonstration period using the CMS PPS hospital market basket index.

(3) Total Medicare Patient Days shall be derived from Worksheet S-3, Part I, Column 6, Line 14 of the same cost report as the Total Medicare Payments. Total Medicare Patient Days shall not include swing bed days.

(4) An Imputed Medicare Per Diem Payment Rate shall be calculated by dividing the inflated Total Medicare Payments by the hospital's Total Medicare Patient Days.

(5) The Imputed Medicare Per Diem Payment Rate shall be multiplied by the total Medicaid Patient Days of the same cost report period as the Total Medicare Payments to derive the hospital's Upper Payment Limit.

(6) The data source for Vidant Medical Center's total number of Medicaid Patient Days and Total Medicaid Payments shall be the hospital's Medicaid PS&R for the same cost report period as the Total Medicare Payments and run no less than six (6) months after the close of the cost report period.

(7) Total Medicaid Payments shall be inflated from midpoint of the hospital's cost report period to the midpoint of the UPL demonstration period using the CMS PPS hospital market basket index.

(8) Vidant Medical Center's inflated Total Medicaid Payments shall be subtracted from the hospital's UPL to obtain the Available Room Under the UPL.

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DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT

With respect to hospitals that are licensed by the State of North Carolina, that are qualified to certify public expenditures (CPEs) and do certify in accordance with 42 CFR 433.51(b), that qualify for disproportionate share hospital status under Paragraph (c) of the "Disproportionate Share Hospital Payment" Section, the expenditures claimable for Federal Financial Participation (FFP) for the 12-month period ending September 30 each year will be the hospitals' uncompensated care expenditures for serving uninsured patients up to the State's available DSH allotment after allowing for DSH payments for the State-owned Institutes for Mental Diseases and Basic DSH. Each hospital's allowable uncompensated care costs for the rate year will be determined on an interim basis by calculating the hospital's inpatient and outpatient cost-to-charge ratios determined from the hospitals' most recent available as-filed CMS 2552 cost report and multiplying the ratios by the hospital's inpatient and outpatient charges, respectively, for uninsured patients as filed with and certified to the Division for the fiscal year. The Division will then subtract payments hospitals received from uninsured patients for services rendered during the fiscal period to which the gross charges referred to in the preceding sentence relate. The Division will bring the uncompensated care cost data forward to the end of the payment period by applying the applicable CMS PPS Hospital Input Price Indices. Hospitals' final allowable costs for services provided to uninsured patients will be determined based upon “Audit of Disproportionate Share Payments” section and requirements in 42 U.S.C. § 1396r-4(j).

(a) In accordance with 42 U.S.C. § 1396r-4 (g)(1) total disproportionate share payments to a hospital shall not exceed the percentage specified by 42 U.S.C. § 1396r-4 (g) of the total costs of providing inpatient and outpatient services to Medicaid and uninsured patients for the fiscal year in which such payments are made, less any Medicaid and uninsured payments received for services to Medicaid and uninsured patients. The total of all disproportionate share hospital payments shall not exceed the limits on disproportionate share hospital fundingas established for this State by CMS in accordance with 42 U.S.C. § 1396r-4 (f).

(b) The payments authorized by this section shall be effective in accordance with GS 108A-55(c).

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(c) No hospital may receive disproportionate share hospital payments unless it:

(1) Has a Medicaid inpatient utilization rate of not less than one percent, defined as the percentage resulting from dividing Medicaid patient days by total patient days, based on the most current available information; and

(2) Has at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals eligible for Medicaid. In the case of a hospital located in a rural area, the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric services procedures. This requirement does not apply to a hospital which did not offer non-emergency obstetric services as of December 21, 1987 or to a hospital that predominantly serves individuals under 18 years of age.

(d) The following Subparagraphs describe additional criteria, at least one of which a hospital must meet to be eligible for disproportionate share hospital payments under certain paragraphs of this Section, as specified in those paragraphs.

(1) The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals that receive Medicaid payments in the state: or

(2) The hospital's low-income utilization rate exceeds 25 percent. The low-income utilization rate isthe sum ~~o~~f:

(A) The ratio of the sum of Medicaid net revenues for patient services plus cash subsidies received from the State and local governments divided by the hospital's net patient revenues; and

(B) The ratio of the hospital's gross inpatient charges for charity care less the cash subsidies for inpatient care received from the State and local governments, divided by the hospital's total inpatient charges; or

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BASIC DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT

(e) Each hospital that qualifies for disproportionate share status under Paragraph (c) and (d) of the "Disproportionate Share Hospital Payment" section of this plan and is eligible to receive a disproportionate share hospital payment, shall receive a Basic DSH payment for the 12-month period ending September 30 each year. The federal share of the aggregate Basic DSH payment to eligible hospitals in this section shall not exceed $10 million. Hospitals eligible for a payment under this section shall receive a proportional payment of the aggregate amount based on each hospital's percentage of outpatient costs for patients without health insurance (or other third party coverage) to the aggregate of outpatient costs for patients without health insurance (or other third party coverage) as described in the Disproportionate Share Hospital Payment" section of this plan.

If a payment to a hospital under this section would cause a hospital to exceed the hospital-specific limits on disproportionate share hospital payments at 42 U.S.C. § 1396r-4(g)(1)(A), payments under this section will be reduced to ensure compliance with the hospital-specific limit.

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STATE-OWNED INSTITUTIONS FOR MENTAL DISEASES DSH PAYMENT

(f) Hospitals operated by the Department of Mental Health that qualify for disproportionate share hospital status under Subparagraph (c) will be eligible for disproportionate share payments, in addition to other payments made under the North Carolina Medicaid Hospital reimbursement methodology, based on bed days of service to low income persons.

(1) Payment shall equal the facility-specific average per diem cost from its most recent cost report available at the time of data collection multiplied by bed days of service to low income persons.

(2) "Bed days of service to low income persons" is defined as the number of bed days provided to individuals that have been determined by the hospital as:

i. Patients who do not possess the financial resources to pay portions or all charges associated with care provided; and

ii. Who do not possess health insurance which would apply to the service for which the individual sought treatment; or

iii. Who have insurance but are not covered for the particular service rendered or for the procedure or treatment.

(3) Payments to Institutes for Mental Diseases under Paragraph (f) shall not exceed the State's DSH limit for Institutes for Mental Disease.

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Audit of Disproportionate Share Payments:

As required by 42 U.S.C. § 1396r-4(j) related to auditing and reporting of disproportionate share hospital payments, the Division of Health Benefits will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded.

Any funds recouped as a result of audits or other corrections shall be redistributed to other eligible hospitals within the state, provided each hospital remains below their hospital specific DSH limit. Funds shall be redistributed to the state hospital with the highest Medicaid Inpatient Utilization Rate (MIUR). Any remaining funds available for redistribution shall be redistributed first to other state hospitals in the order of MIUR from highest to lowest, then to government non-state hospitals in the order of MIUR from highest to lowest, then to private hospitals in the order of MIUR from highest to lowest.

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